Kentucky Permit Number
MG_____

DON'T FORGET!

KENTUCKY BOARD OF PHARMACY
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601
Phone (502) 564-7910
Fax (502) 696-3806
e-mail: pharmacy.board@ky.gov
http://pharmacy.ky.gov

APPLICATION FOR SPECIAL-MEDICINAL GAS PERMIT RENEWAL

Enclose a check or money order for $100.00, made payable to 'Kentucky State Treasurer'. Please print legibly and complete this application; including the required original signature and return to the Board office no later than June 30th.

Facility Name _____ Permit No. _____

Address _____

_____

_____

Telephone No. _____ Fax No. _____

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

OWNERSHIP:

_____Sole Proprietor _____Partnership _____Corporation _____LLC _____Other

Name and title for each owner/officer, including professional designation:

_____

_____

_____

CONSULTANT PHARMACIST*:

Name _____ KY License No. _____

***Consultant Pharmacists are not required for non-resident medicinal gas permits.**

Kentucky Pharmacy Regulation 201 KAR 2:205 requires Consultant Pharmacist to notify the Board within fourteen (14) calendar days of all pharmacist personnel changes.

Schedule of Store Hours: Consultant Pharmacist must notify the Board within fourteen (14) days of any changes in scheduled hours.

Monday . . . . _____ A.M. to _____ P.M. Thursday . . . _____ A.M. to _____ P.M. Sunday . . _____ A.M. to _____ P.M.

Tuesday . . . _____ A.M. to _____ P.M. Friday . . . _____ A.M. to _____ P.M.

Wednesday ._____ A.M. to _____ P.M. Saturday ._____ A.M. to _____ P.M.

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the Regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws. [If applicable, this pharmacy is currently licensed and in good standing in all states of licensure].

_____ _____

(Date) *(Signature of Owner)*